PRINTED: 10/24/2022 FORM APPROVED

CENTERS FO	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155775		IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		B. WING		10/04/2022		
			<u> </u>			
NAME OF	PROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP COD		
				CUMBERLAND AVE		
CUMBE	RLAND POINTE HE	EALTH CAMPUS	WEST	LAFAYETTE, IN 47906		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)	
PREFIX		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	,	R LSC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
F 0000						
1 0000						
Bldg. 00						
Diag. 00	This visit was for the	ne Investigation of Complaints	F 0000	The submission of this plan of	:	
	This visit was for the Investigation of Complaints IN00390828 and IN00379979.		F 0000	The submission of this plan of		
	11N00390828 and 11	NOO3/99/9.		correction does not indicate an		
	C 1 : 4 D 100204	2020 5 1 4 4 4 1		admission by Cumberland Po		
	-	0828 - Substantiated.		Health Campus that the findings and allegations contained herein are accurate, true representation		
		encies related to the				
	allegations are cited	1 at F'/60.				
				of the quality of care provided		
	_	9979 - Substantiated. No		the living environment provide	d to	
	deficiencies related	to the allegations are cited.		the residents of Cumberland		
				Pointe Health Campus. The fa	acility	
	Survey dates: Septe	ember 30, October 3 and 4, 2022		recognizes its obligation to pro	ovide	
				legally and medically necessa	ry	
	Facility number: 00	00547		care and services to its reside	nts	
	Provider number: 1	55775		in an economic and efficient		
	AIM number: 1002	67440		manner. The facility hereby		
				maintains it is in substantial		
	Census Bed Type:			compliance with all state and		
	SNF/NF: 35			federal requirements governing	a the	
	SNF: 21			management of this facility. It	-	
	Residential: 43			thus submitted as a matter of	.	
	Total: 99			statute only. The facility		
				respectfully requests from the		
	Census Payor Type	•		department a desk review for		
	Medicare: 4	•		substantial compliance.		
	Medicaid: 33			Substantial compilance.		
	Other: 19					
	Total: 56					
	10141. 50					
	This deficiency seff	ects State Findings cited in				
	1	_				
	accordance with 41	U IAC 10.2-3.1.				
	0 10	1 . 1 . 0 . 1 . 11				
		completed on October 11,				
	2022.					
E 0760	400 45(5)(0)					
F 0760	483.45(f)(2)					
SS=D		ee of Significant Med Errors				
Bldg. 00	The facility must e	ensure that its-	1	1	1	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Event ID: QYXG11 Facility ID: If continuation sheet Page 1 of 4

TITLE

PRINTED: 10/24/2022 FORM APPROVED

CENTERS FOR	MEDICARE & MEDIC		_		OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155775	B. WING		10/04/2022	
					L	
NAME OF P	ROVIDER OR SUPPLIER	3		ADDRESS, CITY, STATE, ZIP COD		
TWINE OF T	NO VIDER OR SOLVEIEL	•	1051 (CUMBERLAND AVE		
CUMBER	RLAND POINTE HE	ALTH CAMPUS	WEST	LAFAYETTE, IN 47906		
(VA) ID	CIDALADV	OT A TEMENT OF DEFICIENCIE		1	(375)	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX			PREFIX	CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	§483.45(f)(2) Res	idents are free of any				
	significant medica	tion errors.				
	Based on interview	and record review, the facility	F 0760	1. There was 1 resident	10/18/2022	
	failed to keep a resi	dent free of significant		affected. Resident B had		
	medication errors w	hen the resident was given		discharged from facility prior to	0	
		d not given medication as		survey entrance.		
		sician for 1 of 3 residents		Any resident receiving		
	reviewed for medication errors. (Resident B)			medications has potential to b	e	
	10 viewed for intedic	unon errors. (Resident B)		affected. The DHS or designed		
	Finding includes:			will audit all MARs to review for		
	rinding includes.					
	ъ	0/20/2022 / 4.11		omitted or late medication		
	_	v, on 9/30/2022 at 4:11 p.m., a		administrations and notify the		
		icated Resident B was not given		provider as indicated.		
	_	lopa (a medication for		3. The DHS or designee will		
) at 8:00 p.m., on 9/16/2022.		provide education to nurses a	nd	
	The medication was	s to be given every 4 hours.		QMAs on medication		
				administration related to		
	The record for Resi	dent B was reviewed on		medication error and time		
	10/3/2022 at 1:50 p	.m. Diagnoses included, but		management.		
	were not limited to,	Parkinson's disease, tremors,		4. DHS or designee will aud	dit	
	hypertension and m			medication administrations		
				records of 10 residents for any	<i>,</i>	
	The Medication Ad	ministration Record (MAR)		omitted or late medication	´	
		B was to receive his		administrations weekly for 4		
		a 25-250 mg (milligram)		weeks, then 10 residents ever	-v	
		hours. The resident received		other week for 4 weeks, then	-	
		1/13/2022 at 9:58 a.m., instead of				
	8:00 a.m.	1312022 at 3.36 a.iii., iiisteau 01		residents monthly for 4 month	5 UI	
	0.00 a.III.			until 100% compliance is		
	TI MAD' 1' · ·	ID 11 (D) 1 11		achieved. Findings will be		
		Resident B was to receive his		reviewed in QA.		
		25-250 mg medication every 4		5. Substantial compliance	WIII	
		received his medication on		be achieved by 10/18/2022		
	9/13/2022 at 1:30 p	.m., instead of 12:00 p.m.				
	The MAR indicated	l Resident B was to receive his				
	carbidopa-levodopa	25-250 mg medication every 4				
	hours. The resident	did not receive his medication				
	on 9/13/2022 at 4:0	0 a.m.				
			1			

The MAR indicated Resident B was to receive his

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
		155775	B. W	B. WING		10/04/2022	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	2		1	UMBERLAND AVE		
CLIMBEE	SI AND POINTE HE	ALTH CAMPLIS			_AFAYETTE, IN 47906		
CUMBERLAND POINTE HEALTH CAMPUS				WLST	-AI AI EI I E, III 47 900		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
	carbidopa-levodopa 50-200 mg medication every 4						
		received his medication on					
	9/13/2022 at 9:58 a	.m., instead of 8:00 a.m.					
		l Resident B was to receive his					
		50-200 mg medication every 4					
		received his medication on					
	9/13/2022 at 1:30 p	.m., instead of 12:00 p.m.					
	The MAR indicated	l Resident B was to receive his					
		25-250 mg medication every 4					
		did not receive his medication					
	on 9/14/2022 at 12:						
	During an interview	v, on 10/3/2022 at 2:30 p.m.,					
	with the Minimum	Data Set (MDS) nurse 2 and the					
	Regional Clinical S	upport (RCS) 3 regarding					
	Resident B's medica	ation administration, MDS					
	nurse 2 indicated R	esident B received his					
	medication carbido	pa-levodopa 25-250 mg on					
	9/13/2022 late at 9:	58 a.m., instead of 8:00 a.m., per					
	physician orders. T	he RCS 3 indicated Resident B					
	received his medica	ation carbidopa-levodopa					
	25-250 mg on 9/13/2022 late at 1:30 p.m., instead						
	12:00 p.m., per physician order. The MDS nurse 2						
	indicated Resident B did not receive his						
	carbidopa-levodopa	25-250 mg medication on					
	9/14/2022 at 12:00	a.m., per physician order. The					
	RCS 3 indicated Re	esident B did not receive his					
	carbidopa-levodopa	25-250 mg medication on					
	9/14/2022 at 4:00 a	.m., per physicians order.					
		10/0/0000					
	_	v, on 10/3/2022 at 2:40 p.m.,					
		e 2 and the RCS 3 regarding					
	Resident B's medication administration, the MDS						
	nurse 2 indicated Resident B received his						
		pa-levodopa 50-200 mg on					
	9/13/2022 late at 9:58 a.m., instead of 8:00 a.m. On 9/13/2022, Resident B received his medication						
	carbidopa-levodopa	25-250 mg at 1:30 p.m.,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QYXG11 Facility ID: 000547

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/24/2022 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155775		ILDING	onstruction 00	(X3) DATE COMPL 10/04/	LETED
NAME OF PROVIDER OR SUPPLIER CUMBERLAND POINTE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP COD 1051 CUMBERLAND AVE WEST LAFAYETTE, IN 47906				
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPRODUCT TAG DEFICIENCY)		TE	(X5) COMPLETION DATE
	RCS 3 indicated Re carbidopa-levodopa 8:00 p.m., on the ev not recieve it.	n., per physicians order. The sident B did receive his medication for 9/16/2022 at rening his family thought he did ates to Complaint IN00390828.					

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: QYXG11 Facility ID: 000547 If continuation sheet Page 4 of 4